

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH 10121

County Montgomery

Village or City Rockville (No.)

2 FULL NAME Otha Baker

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|------------|-------------------------|--|
| 3 SEX Male | 4 COLOR OR RACE Colored | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single |
|------------|-------------------------|--|

| | | | |
|-------------------------|---------|-------|----------|
| 6 DATE OF BIRTH Unknown | (Month) | (Day) | (Year) 1 |
|-------------------------|---------|-------|----------|

| | | | |
|---------------|------|-----|---------------------------------------|
| 7 AGE 75 yrs. | mos. | ds. | If LESS than 1 day, hrs. OR min. ? |
|---------------|------|-----|---------------------------------------|

| | |
|---|--|
| 8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer Laborer | (b) General nature of industry, business, or establishment in which employed (or employer) |
|---|--|

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| 9 BIRTHPLACE (State or country) Maryland |
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|---------------------------------|
| 10 NAME OF FATHER William Baker |
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| 11 BIRTHPLACE OF FATHER (State or country) Maryland |
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|----------------------------------|
| 12 MAIDEN NAME OF MOTHER Unknown |
|----------------------------------|

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|---|
| 13 BIRTHPLACE OF MOTHER (State or country) Maryland |
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|--|
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE |
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| |
|---------------------------|
| (Informant) Thomas Dawson |
|---------------------------|

| |
|--------------------------|
| (Address) Rockville, Md. |
|--------------------------|

| |
|----------------|
| 15 Filed. 1911 |
|----------------|

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 28, 1914 (Month Day Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1914, to Oct 25, 1914,

that I last saw him alive on Oct 25, 1914, and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Ocerebral hemorrhage

(Duration) yrs. mos. 5 ds.
Contributory Arteric Schlerosis
Secondary

(Duration) 5 yrs. mos. ds.
(Signed) Edward Anderson, M. D.
, 191 (Address) Rockville, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place 75 yrs. mos. ds. In the State 75 yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or usual residence Rockville, Md.

19 PLACE OF BURIAL OR REMOVAL

At Rockville, Md. Oct 28, 1914

20 UNDERTAKER W. R. Lumpkin ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "*Anæmia*," "*Anæmia*" (merely symptomatic), "*Atrophy*," "*collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("Con-^{genital}," "*Senile*," etc.), "*Dropsey*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Mars-*^{mus}," "*Old Age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



REVISED UNITED STATES STANDARD

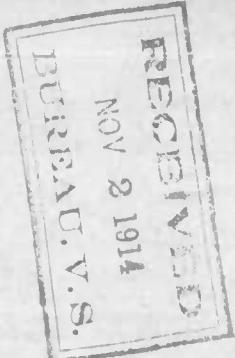
CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dairylaborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*



oma

Sarcoma, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Mesles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | |
|---|---|--|
| 1 PLACE OF DEATH | | 10123 |
| County <u>Montgomery</u> | | (No. <u>79</u>) |
| Village or City <u>Rockville</u> | | |
| 2 FULL NAME <u>Eliza Blair</u> | | |
| PERSONAL AND STATISTICAL PARTICULARS | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <small>(Write the word)</small> <u>Married</u> |
| 8 DATE OF BIRTH <u>Unknown</u> (Month) (Day) (Year) | | |
| 7 AGE <u>66 yrs.</u> | If LESS than 1 day, ____ hrs. OR min. ? | |
| 8 OCCUPATION <u>Cook</u> | | |
| (a) Trade, profession, or particular kind of work. | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| 9 BIRTHPLACE <u>Maryland</u> (State or country) | | |
| 10 NAME OF FATHER <u>Grafton Brown</u> | | |
| 11 BIRTHPLACE OF FATHER <u>Maryland</u> (State or country) | | |
| 12 MAIDEN NAME OF MOTHER <u>Unknown</u> | | |
| 13 BIRTHPLACE OF MOTHER <u>Maryland</u> (State or country) | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Joseph Cooper</u> (Address) <u>Rockville, Md.</u> | | |
| 15 Filed _____, 19 <u>11</u> | | |

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 213

St. _____ Ward _____

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 9, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Sept. 3rd, 1914, to Sept. 3rd, 1914,
that I last saw her alive on Sept. 3rd, 1914,
and that death occurred on the date stated above, at 5 P.M..
The CAUSE OF DEATH* was as follows:Cardiac and Disease of Heart(Duration) 3 yrs. 0 mos. 0 ds.Contributory Cardiac Disease
Secondary(Duration) 0 yrs. 0 mos. 0 ds.(Signed) Edward Anderson, M. D.
(Oct. 13th, 1914) (Address) Rockville, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place 66 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.Where was disease contracted,
if not at place of death?Former or
usual residence Res Rockville, Md.19 PLACE OF BURIAL OR REMOVAL Rockville, Md. DATE OF BURIAL Oct. 13, 191420 UNDERTAKER M. R. Pamphrey ADDRESS Rockville, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

NOV 7 1914

BUREAU U. S. S.

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1 PLACE OF DEATH 10124

County Maryland

Village or City Quince Orchard (No.)

91

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mary Louise Brown

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|----------------------------|-------------------------|---|
| 3 SEX Female | 4 COLOR OR RACE Colored | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single |
| 6 DATE OF BIRTH Sept 19 | | (Month) (Day) (Year) 1913 |
| 7 AGE 1 yrs. 0 mos. 21 ds. | | If LESS than 1 day, hrs. OR min. ? |

| | |
|--|--|
| 8 OCCUPATION | |
| (a) Trade, profession, or particular kind of work | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | |

| | |
|---------------------------------|--|
| 9 BIRTHPLACE (State or country) | |
| Maryland | |

| | |
|--|--|
| 10 NAME OF FATHER | |
| John Brown | |
| 11 BIRTHPLACE OF FATHER (State or country) | |
| Maryland | |
| 12 MAIDEN NAME OF MOTHER | |
| Ella Ricky | |
| 13 BIRTHPLACE OF MOTHER (State or country) | |
| Maryland | |

| | |
|--|--|
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | |
| (Informant) John Brown | |
| (Address) Gaithersburg P.O. Md | |

15 Filed Oct 5, 1914 C.H. Cuthbert M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 4, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 4, 1914, to Oct 4, 1914, that I last saw him alive on Oct 4, 1914, and that death occurred on the date stated above, at 11:00 a.m. The CAUSE OF DEATH* was as follows:

Rheumatic Peritonitis
 (Duration) yrs. mos. 10 ds.
 Contributory Secondary Exhaustion
 (Duration) yrs. mos. 2 ds.
 (Signed) C.H. Cuthbert, M.D.
 Oct 5, 1914 (Address) Gaithersburg Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. 21 ds. In the State yrs. mos. 21 ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence Same

19 PLACE OF BURIAL OR REMOVAL

Quince Orchard Oct 5, 1914

20 UNDERTAKER

W. R. Murphy Son Rockville Md

DATE OF BURIAL

ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

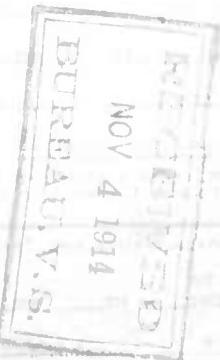
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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cercospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensus*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | | | | |
|---|-----------------------------|---|--|--|
| 1 PLACE OF DEATH County..... | | 10125 | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City (No.) | | C. D. 175 Registration Dist. No. 213 | | |
| 2 FULL NAME Harry Lee Butler | | St.; Ward) | | |
| | | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <i>m</i> | 4 COLOR OR RACE <i>w</i> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Widowed</i> | 16 DATE OF DEATH Oct 17, 1914 (Month) (Day) (Year) | |
| 6 DATE OF BIRTH <i>Apr 23, 1871</i> (Month) (Day) (Year) | | If LESS than 1 day, hrs. OR min. ? | 17 I HEREBY CERTIFY, That I attended deceased from No physician in attendance about 45 m., that I last saw h. alive at about 10 a.m., and that death occurred on the date stated above, at 10 a.m., The CAUSE OF DEATH* was as follows: <i>Menorrhage from nose & ear caused by fracture of skull & concussion of brain, cause unknown but symptoms from electric a very minute Contributory Secondary or was known from old age (probably) (Duration) 1 yr. mos. ds.</i> | |
| 7 AGE <i>43 yrs. 5 mos. 24 ds.</i> | | | (Signed) R. K. Mannat, M. D. County Health Officer, Rockville (Address) | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work... <i>Farmer</i> (b) General nature of industry, business, or establishment in which employed (or employer)... <i>Farming</i> | | | | |
| 9 BIRTHPLACE (State or country) <i>Md</i> | | | | |
| 10 NAME OF FATHER <i>Charles M. Butler</i> | | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <i>Virginia</i> | | | | |
| 12 MAIDEN NAME OF MOTHER <i>Frances J. Spates</i> | | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <i>Maryland</i> | | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Wm G. Butler (Brother)</i> (Address) <i>Near Rockville</i> | | | | |
| 15 Filed....., 191 | | | | |
| REGISTRAR | | | | |
| 16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds Where was disease contracted, if not at place of death? Former or usual residence. | | | | |
| 17 PLACE OF BURIAL OR REMOVAL <i>Beallsville, Md</i> DATE OF BURIAL <i>Oct 20, 1914</i> | | | | |
| 20 UNDERTAKER <i>W. R. Humphrey</i> ADDRESS <i>Rockville Md.</i> | | | | |
| If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1. | | | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
NOV 7 1914

BUREAU, V.S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

¹ PLACE OF DEATH 10126
County Maryland

43

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 216

Village or City Chevy Chase (No. 11), Quincy St., — Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

²FULL NAME Susie Fillmore Camp.

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|-------------------------|----------------------------------|---|
| ³ SEX Female | ⁴ COLOR OR RACE white | ⁵ SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word) Married |
|-------------------------|----------------------------------|---|

⁶ DATE OF BIRTH

July 21, 1873
(Month) (Day) (Year)

⁷ AGE

41 yrs. 2 mos. 9 ds.
It LESS than
1 day, hrs.
OR min. ?

⁸ OCCUPATION

- (a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer)

none

⁹ BIRTHPLACE

(State or country)

D.C.

¹⁰ NAME OF FATHER

George Nieland Fillmore

¹¹ BIRTHPLACE OF FATHER

(State or country)

Minn.

¹² MAIDEN NAME OF MOTHER

Sotie Ann Norfleet

¹³ BIRTHPLACE OF MOTHER

(State or country)

Washington D.C.

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sotie Fillmore Norfleet

(Address) Suffolk, Va.

¹⁵

Filed Apr. 8, 1914 Thos H. Leonard M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH Oct 6, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from May, 1913, to Oct 6, 1914,

that I last saw her alive on Oct 6, 1914,

and that death occurred on the date stated above, at 10:00 p.m.

The CAUSE OF DEATH* was as follows:

Sudden Paroxysm a
of the liver following carcinoma
of breast,
about (Duration) 1 yrs. - mos. - ds.

Contributory
Secondary

Epilepsy
(Duration) 3 yrs. - mos. - ds.
(Signed) Ryan Worcester, M.D.
Oct. 7, 1914 (Address) Chevy Chase Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence.

¹⁹ PLACE OF BURIAL OR REMOVAL

Washington, D.C. Oct 9, 1914

²⁰ UNDERTAKER

Jos. Sawyer's Sons ADDRESS

1730 Pennsylvania Ave.
West, D.C.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

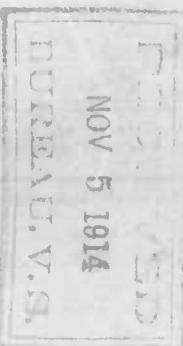
CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meunges, peritonaeum, etc.*, *Carcin-*oma, *Sarcoma*, etc. of, (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | |
|--|------------------------|---|--------------------|
| PLACE OF DEATH | | 10127 | <i>(Signature)</i> |
| County | | Montgomery | |
| Village or City | | Potowac. | |
| (No.) | | | |
| FULL NAME | | | |
| Infant of Joseph A. Cose | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | |
| Female. | White | Single | |
| 6 DATE OF BIRTH | | | |
| Oct | | 27 | , 1914 |
| (Month) | | (Day) | (Year) |
| 7 AGE | | | |
| Sick-born | | If LESS than 1 day, ____ hrs. OR ____ min. ? | |
| yrs. mos. ds. | | | |
| 8 OCCUPATION | | | |
| (a) Trade, profession, or particular kind of work <input checked="" type="checkbox"/> | | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) <input checked="" type="checkbox"/> | | | |
| 9 BIRTHPLACE (State or country) | | | |
| Montgomery Co. Md. | | | |
| 10 NAME OF FATHER | | | |
| Joseph Albury Cose. | | | |
| 11 BIRTHPLACE OF FATHER (State or country) | | | |
| Montgomery Co. Md. | | | |
| 12 MAIDEN NAME OF MOTHER | | | |
| Elsie May, Ricetti. | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) | | | |
| Montgomery Co. Md. | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | |
| (informant) Joseph A. Cose. | | | |
| (Address) Potowac, Md. | | | |
| 15 Filed Oct 28, 1914 Mrs. McGinnis H. S. Local. REGISTRAR | | | |

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 219

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Sick-born Oct 27, 1914*
(Month) (Day) (Year)

17 I HEREBY CERTIFY, THAT I attended deceased from
Oct 27, 1914 to Oct 27, 1914
that I last saw her *alive on Oct 27, 1914*

and that death occurred on the date stated above, at *10:00 P.M.*
The CAUSE OF DEATH* was as follows:

Sick Birth

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) *M. P. Hall* Oct 27, 1914 (Address) *Potowac, Md.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Potowac, Md.* **DATE OF BURIAL** *Oct 29, 1914*

20 UNDERTAKER *W. H. Murphy* **ADDRESS** *Rockville, Md.*

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coat mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Can-
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERAL septicæmia," "PUERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | |
|---------------|------------|
| RECEIVED | NOV 6 1914 |
| BUREAU, V. S. | |

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | | |
|---|--|--|---|--------------------|
| 1 PLACE OF DEATH County <i>Maryland</i> | | 10128 | STATE OF MARYLAND CERTIFICATE OF DEATH | |
| Village or City <i>Wheaton</i> | | (No.) | Registration Dist. No. <i>222</i> | |
| 2 FULL NAME <i>Howard C Davis</i> | | St. _____ Ward _____ | [If death occurred in a hospital or institution, give its NAME instead of street and number.] | |
| PERSONAL AND STATISTICAL PARTICULARS | | | | |
| 3 SEX <i>Male</i> | 4 COLOR OR RACE <i>Colored</i> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>Single</i> | MEDICAL CERTIFICATE OF DEATH | |
| 6 DATE OF BIRTH <i>Sept. 1, 1914</i> | | Month (Month) Day (Day) Year (Year) | 16 DATE OF DEATH <i>Oct 29, 1914</i> | (Month) Day (Year) |
| 7 AGE <i>1 yrs. 1 mos. 15 ds.</i> | | If LESS than 1 day, hrs. OR min. ? | 17 I HEREBY CERTIFY. That I attended deceased from _____, 191____, to _____, 191____, that I last saw him alive on <i>Oct 15, 1914</i> and that death occurred on the date stated above, at <i>4 P.M.</i> The CAUSE OF DEATH* was as follows: | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <i>None</i> | | <i>Enteritis</i> | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) <i>—</i> | | | | |
| 9 BIRTHPLACE (State or country) <i>Md</i> | | (Duration) yrs. <i>1</i> mos. <i>3</i> ds. | | |
| 10 NAME OF FATHER <i>Henry H. Davis</i> | | Contributory Secondary <i>Malaria</i> | | |
| 11 BIRTHPLACE OF FATHER (State or country) <i>Md</i> | | (Operation) yrs. <i>1</i> mos. <i>29</i> ds. | | |
| 12 MAIDEN NAME OF MOTHER <i>Emma Buckley</i> | | (Signed) <i>W. L. Lewis</i> , M. D. <i>Oct 31, 1914</i> (Address) <i>Wheaton</i> | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <i>Md</i> | | * State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>Henry H. Davis</i> (Address) <i>Wheaton</i> | | | | |
| 15 Filed <i>Oct 29, 1914</i> | 16 PLACE OF BURIAL OR REMOVAL <i>Wheaton</i> | DATE OF BURIAL <i>Oct 30, 1914</i> | | |
| 17 UNDERTAKER <i>Henry H. Davis</i> | | ADDRESS <i>Wheaton</i> | | |

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer-Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia"; unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc., Cancer-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

10129

County Montgomery

28

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218

St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Washington D.C. (No.)2 FULL NAME Irene Davis

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|------------------|----------------------------|---|
| ³ SEX | ⁴ COLOR OR RACE | ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
| <u>Female</u> | <u>Colored</u> | <u>Single</u> |

⁶ DATE OF BIRTH
Oct 1, 1893
 (Month) (Day) (Year)

⁷ AGE
21 yrs. 9 mos. 14 ds. If LESS than
 t day, ____ hrs.
 OR min. ?

⁸ OCCUPATION
 (a) Trade, profession, or
 particular kind of work.
Cook
 (b) General nature of industry,
 business, or establishment in
 which employed (or employer)

⁹ BIRTHPLACE
 (State or country)
Md

¹⁰ NAME OF
 FATHER
Thomas Davis

¹¹ BIRTHPLACE
 OF FATHER
 (State or country)
Md

¹² MAIDEN NAME
 OF MOTHER
Betsie Waters

¹³ BIRTHPLACE
 OF MOTHER
 (State or country)
Md

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Irene Davis

(Address) Washington D.C. Md

15
 Filed Oct 14, 1914 C. B. Etchison M.D.

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH
Oct 12, 1914, 1914
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from
death 1, 1914, to Oct 12, 1914,
 that I last saw him alive on Oct 11, 1914,
 and that death occurred on the date stated above, at 5 P.M.
 The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
 (Duration) 2 yrs. mos. ds.

Contributory
 Secondary
 (Duration) yrs. mos. ds.

(Signed) T. H. Etchison, M. D.
Oct 15, 1914 (Address) Washington D.C.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 2 yrs. 0 mos. 0 ds. In the State 2 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?
Wash. D.C.

Former or usual residence Washington D.C.

¹⁹ PLACE OF BURIAL OR REMOVAL Cemmyrine DATE OF BURIAL Oct 14, 1914

²⁰ UNDERTAKER W. R. Lumpkin, John ADDRESS Rockville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worker on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Oerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPEAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sensis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | |
|--|-------------------------------------|---|
| 1 PLACE OF DEATH | | 10130 |
| County <u>Montgomery</u> | | (S) |
| Village or City <u>Erlinton</u> | (No.) | St. _____ Ward _____ |
| 2 FULL NAME <u>Billy Dorsay</u> | | |
| PERSONAL AND STATISTICAL PARTICULARS | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Negro</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Billy</u> |
| 6 DATE OF BIRTH <u>Oct 12th</u> | | (Month) (Day) (Year) |
| 7 AGE <u>0 yrs. 0 mos. 0 ds.</u> | | It LESS than 1 day, <u>0</u> hrs. OR <u>0</u> min. ? |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Billy</u> | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) <u>✓</u> | | |
| 9 BIRTHPLACE (State or country) <u>Montgomery Co Md</u> | | |
| 10 NAME OF FATHER <u>John Dorsay</u> | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Montgomery Co Md</u> | | |
| 12 MAIDEN NAME OF MOTHER <u>Sallie Randolph</u> | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Montgomery Co Md</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sallie Randolph (X)</u> (Address) <u>Partingaling Rd No 40</u> | | |
| 15 | Filed <u>Oct 13, 1914</u> D 11 Dyer | |

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 210

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

| | | |
|--|---------|------------------------------------|
| MEDICAL CERTIFICATE OF DEATH | | |
| 16 DATE OF DEATH <u>October 13th, 1914</u> | (Month) | (Day) (Year) |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 13, 1914</u> to <u>Oct 13, 1914</u> , that I last saw him alive on <u>Oct 13, 1914</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Suffocation - died died in water only about 8 mo terms. S. K. S. Encrusted when down -</u> (Duration) <u>yrs. mos. ds.</u> | | |
| Contributory Secondary | | |
| (Duration) <u>yrs. mos. ds.</u> | | |
| (Signed) <u>Clifford W. Wilkins</u> M. D. <u>Oct 13, 1914</u> (Address) <u>Laytonsville Md</u> | | |
| * State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI- DENTAL, SUICIDAL, or HOMICIDAL. | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>yrs. mos. ds.</u> In the State <u>yrs. mos. ds.</u> Where was disease contracted, if not at place of death? Former or usual residence. | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Erlinton. Offutt Cemetery</u> | | DATE OF BURIAL <u>Oct 13, 1914</u> |
| 20 UNDERTAKER <u>J F Burns</u> | | ADDRESS <u>Laytonsville</u> |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

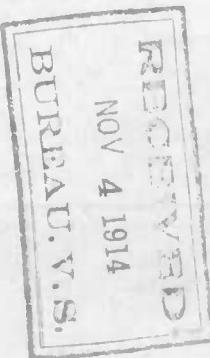
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*.

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

10131

(60)

Village or City Ashton (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 217

St.: _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME John L. Slosey.

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|-----------------------------|--|---|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>Colored</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u> |
|-----------------------------|--|---|

6 DATE OF BIRTH
Unknown, 1898
(Month) (Day) (Year)

7 AGE
16 yrs. Unknown mos. 0 ds.
IT LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
Farm Worker
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country) Maryland

10 NAME OF FATHER
William Slosey.

11 BIRTHPLACE OF FATHER
(State or country) Maryland

12 MAIDEN NAME OF MOTHER
Harriett A. Matthews

13 BIRTHPLACE OF MOTHER
(State or country) Tenn.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank S. S.

(Address) Ashton.

15
Filed 10-6 - 1914 Chas. Farquhar

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH
10 5, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 10/4/1914, to 10/5/1914,
that I last saw him alive on 10/5/1914,
and that death occurred on the date stated above, at 11:55 P.M.

The CAUSE OF DEATH* was as follows:

Cerebralclerosis

(Duration) yrs. mos. 5 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.
(Signed) J. D. Bell Family Physician, M. D.
10/4/1914 (Address) Ashton

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL
Shady St. **DATE OF BURIAL**
10/7/1914

20 UNDERTAKER
S. H. Snodden **ADDRESS**
Burkeville Rd.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the illness causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease

CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrphy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

NOV 2 1914

BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery
Village or City Boyds

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 211

2 FULL NAME

(Still-Born) Edwards

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|-------------------|------------------------------|---|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word) |
|-------------------|------------------------------|---|

| | | | |
|-------------------------------------|---------|-------|--------|
| 6 DATE OF BIRTH <u>Oct. 9, 1914</u> | (Month) | (Day) | (Year) |
|-------------------------------------|---------|-------|--------|

| | |
|-----------------|--|
| 7 AGE <u> </u> | If LESS than 1 day, _____ hrs. yrs. mos. ds. hrs. min. ? |
|-----------------|--|

| | |
|--|---|
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u> </u> | (b) General nature of industry, business, or establishment in which employed (or employer) <u> </u> |
|--|---|

| |
|--|
| 9 BIRTHPLACE (State or country) <u>Boyds, Md.</u> |
|--|

| |
|---|
| 10 NAME OF FATHER <u>Samuel Edwards</u> |
|---|

| |
|---|
| 11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u> |
|---|

| |
|--|
| 12 MAIDEN NAME OF MOTHER <u>Thompson</u> |
|--|

| |
|---|
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u> |
|---|

| |
|---|
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Samuel Edwards</u> |
|---|

| |
|------------------------|
| (Address) <u>Boyds</u> |
|------------------------|

| |
|---------------------------------------|
| 15 Filed <u>Oct. 9, 1914 22 cents</u> |
|---------------------------------------|

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 9, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191____, to , 191____,

that I last saw h. alive on , 191____,

and that death occurred on the date stated above, at . m.

The CAUSE OF DEATH* was as follows:

Still-Birth

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Received, 1914, (Address) Clarkesburg, M. D.

(Signature) Edgar, 1914 (Address) Clarkesburg

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Harrow DATE OF BURIAL Oct. 9, 1914

20 UNDERTAKER Samuel Edwards ADDRESS Boyds, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Pianist*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma

etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapsus," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and nil question answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

| |
|--------------|
| RECEIVED |
| BUREAU, V.S. |
| RECEIVED |
| BUREAU, V.S. |

DEC 23 1914

RECEIVED
BUREAU, V.S.
JAN 5 1915

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | | |
|---|------------------------|---|----------|
| 1 PLACE OF DEATH | | 10132 | (S) |
| County. <i>Montgomery</i> | | | |
| Village or City <i>Gaithersburg</i> (No.) | | | |
| 2 FULL NAME <i>Fraser</i> | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word) | 6 |
| <i>Male</i> | <i>white</i> | <i>Single</i> | |
| 8 DATE OF BIRTH | | Oct | 3 |
| | | (Month) | (Day) |
| | | , 1914 (Year) | |
| 7 AGE | | If LESS than 1 day, 0 hrs. or 0 min.? | |
| <i>0 yrs. 0 mos. 0 ds.</i> | | <i>0</i> | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work... <i>August -</i> | | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) ... <i>—</i> | | | |
| 9 BIRTHPLACE (State or country) <i>Maryland</i> | | | |
| 10 NAME OF FATHER <i>Ray Fraser</i> | | | |
| 11 BIRTHPLACE OF FATHER (State or country) <i>Va.</i> | | | |
| 12 MAIDEN NAME OF MOTHER <i>Ella Garrett</i> | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <i>Md</i> | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | |
| (Informant) <i>Ray Fraser</i> | | (Address) <i>Gaithersburg Md</i> | |
| 15 Filed <i>Oct 3 1914 P.M. St. John's Hospital</i> | | REGISTRAR | |

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *218*

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *Oct 3*, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *Oct 3, 1914, to Oct 3, 1914,* that I last saw him alive on *—*, 1914,

and that death occurred on the date stated above, at *—* m.,
The CAUSE OF DEATH* was as follows:

*(Still born)
(Hydrocephalus)*
(Duration) — yrs. — mos. — ds.

Contributory _____
Secondary _____
(Duration) — yrs. — mos. — ds.

(Signed) *H.B. Hadday*, M. D.
Oct 3, 1914 (Address) *Gaithersburg*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL *Gaithersburg* **DATE OF BURIAL** *Oct 3-14*

20 UNDERTAKER *A.S. Cashier* **ADDRESS** *Gaithersburg*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

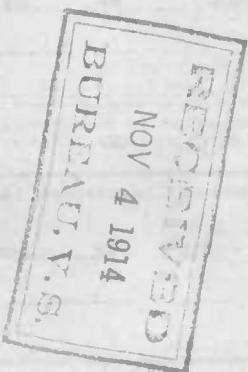
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

oma

"cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery 10133

Village or City Brockville (No.)

2 FULL NAME Rose Giddens

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---------------------|------------------------------|---|
| 3 SEX <u>female</u> | 4 COLOR OR RACE <u>black</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u> |
|---------------------|------------------------------|---|

6 DATE OF BIRTH unknown, 1866
(Month) (Day) (Year)

7 AGE 48 yrs. mos. ds.
if LESS than
1 day, _____ hrs.
OR _____ min.?

8 OCCUPATION
(a) Trade, profession, or
particular kind of work laundress
(b) General nature of industry,
business, or establishment in
which employed (or employer) at home

9 BIRTHPLACE
(State or country) Ind

10 NAME OF
FATHER Henry Johnson

11 BIRTHPLACE
OF FATHER
(State or country) unknown

12 MAIDEN NAME
OF MOTHER Susan Johnson

13 BIRTHPLACE
OF MOTHER
(State or country) unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Renton Johnson

(Address) Brockville Ind

15

Filed 191

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 5th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1914, to Oct 5, 1914,

that I last saw h. or alive on Sep 10th, 1914,

and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage (caused by Chronic nephritis)

(Duration) 2 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Renton Johnson, M. D.
Oct 6, 1914 (Address) Brockville Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds

Where was disease contracted,
if not at place of death? _____

Former or
usual residence _____

19 PLACE OF BURIAL OR REMOVAL Brockville Ind DATE OF BURIAL Oct 6, 1914

20 UNDERTAKER D. R. Murphy ADDRESS Brockville Ind

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

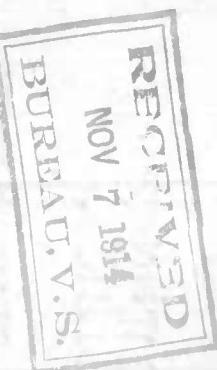
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*Retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, menses, peritonacum*, etc.; *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "*Anesthesia*," "*Anæmia*" (merely symptomatic), "*Aatrophy*," "*Collapse*," "*Coma*," "*Couvolusions*," "*Debility*" ("*Con genital*," "*Senile*," etc.), "*Dropsey*," "*Exhaustion*," "*Heart failure*," "*Haemorrhage*," "*Inanition*," "*Marnus*," "*Old Age*," "*Shock*," "*Uremia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæ mia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County Montgomery **10134**

Village or City Holmeswood (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 210

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Thomas Holmwood Sumner

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--------------|------------------------|--|
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
| <u>Male</u> | <u>White</u> | <u>C</u> |

6 DATE OF BIRTH
11 24, 1918
 (Month) (Day) (Year)

7 AGE
yrs. 11 mos. 9 ds. 0
 If LESS than
 1 day hrs.
 OR min. ?

8 OCCUPATION
 (a) Trade, profession, or
 particular kind of work
None
 (b) General nature of industry,
 business, or establishment in
 which employed (or employer)
C

9 BIRTHPLACE
 (State or country)
Maryland

10 NAME OF FATHER
Howard E. Sumner

11 BIRTHPLACE OF FATHER
 (State or country)
Md

12 MAIDEN NAME OF MOTHER
Estherade O'Conor

13 BIRTHPLACE OF MOTHER
 (State or country)
Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Howard E. Sumner

(Address) Holmwood Md

15
 Filed Aug 30, 1914 by W. H. Taylor

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 10 30, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

10/30/1914 to 10/30/1914,
 that I last saw him alive on 10/30/1914,

and that death occurred on the date stated above, at Sandy Spring m.

The CAUSE OF DEATH* was as follows:

Saynoidal Obstruction due
to stricture today.

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.
 (Signed) J. N. Bush, M. D.

10/30/1914 (Address) Sandy Spring

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL Burkville Cemetery **DATE OF BURIAL** Aug 30, 1914

20 UNDERTAKER J. N. Cashee

ADDRESS
Burkville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

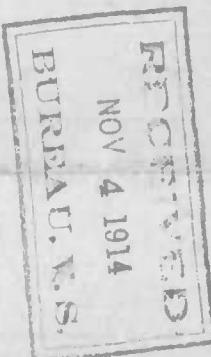
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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Maugger," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

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1 PLACE OF DEATH
County Montgomery
Village or City Georgetown

10135

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218

St.: _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Glenn H. Hammann

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|-------------------|------------------------------|---|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word) |
|-------------------|------------------------------|---|

6 DATE OF BIRTH

Dec 15, 1911
(Month) (Day) (Year)

7 AGE

4 yrs. 10 mos. 4 ds.If LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Md

10 NAME OF FATHER

Jacob Hammann11 BIRTHPLACE OF FATHER
(State or country)Pa.

12 MAIDEN NAME OF MOTHER

Joy Hartley13 BIRTHPLACE OF MOTHER
(State or country)Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Jacob Hammann(Address) Georgetown Md

15

Filed Oct 20, 1914 C. H. Stetson M. D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 18, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct 8, 1914, to Oct 18, 1914,that I last saw him alive on Oct 18, 1914,and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Brain Rupture

(Duration) yrs. mos. /6 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) E. H. Elchison, M. D.
Oct 20, 1914 (Address) Gaithersburg

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds.

Where was disease contracted, _____ State _____ yrs. _____ mos. _____ ds

If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

Gaithersburg DATE OF BURIAL Oct 20, 1914

20 UNDERTAKER

A. G. Carlisle ADDRESS Gaithersburg

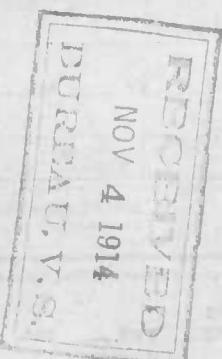
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by earholic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *synsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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BURIAU, V. S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | |
|--|------------------------------|---|
| 1 PLACE OF DEATH County <u>Montgomery</u> | | 10136 |
| Village or City <u>Bethesda</u> | | (No.) |
| 2 FULL NAME <u>Cora Alberta Harris</u> | | |
| PERSONAL AND STATISTICAL PARTICULARS | | |
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>Beige</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word) |
| 6 DATE OF BIRTH <u>Feb. 3, 1914</u> (Month) (Day) (Year) | | |
| 7 AGE <u>8 yrs. 9 mos. 9 ds.</u> It LESS than 1 day, ____ hrs. OR ____ min. ? | | |
| 8 OCCUPATION <u>Name</u> (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| 9 BIRTHPLACE <u>Montgomery Co. Md.</u> (State or country) | | |
| 10 NAME OF FATHER <u>Charles G. Harris</u> | | |
| 11 BIRTHPLACE OF FATHER <u>Montgomery Co. Md.</u> (State or country) | | |
| 12 MAIDEN NAME OF MOTHER <u>Matilda Prather</u> | | |
| 13 BIRTHPLACE OF MOTHER <u>Montgomery Co. Md.</u> (State or country) | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Matilda Harris</u> (Address) <u>Bethesda Md.</u> | | |
| 15 Filed <u>Och 13, 1914</u> John L. Lewis, M.D. REGISTRAR | | |

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 216

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

| | | |
|--|--|--|
| MEDICAL CERTIFICATE OF DEATH | | |
| 16 DATE OF DEATH <u>Och 12, 1914</u> (Month) (Day) (Year) | | |
| 17 I HEREBY CERTIFY, That I attended deceased from <u>Och 5, 1914</u> to <u>Och 12, 1914</u> that I last saw her alive on <u>Och 11, 1914</u> and that death occurred on the date stated above, at <u>3 A.m.</u> The CAUSE OF DEATH* was as follows: <u>Enteritis - Colitis</u> | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ of death _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds Where was disease contracted, If not at place of death? _____ Former or usual residence _____ | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Woodlawn Cemetery, Montgomery Co., Md.</u> DATE OF BURIAL <u>Och 13, 1914</u> | | |
| 20 UNDERTAKER <u>W.L. Murphy Son, Rockville</u> ADDRESS <u>Rockville Md.</u> | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

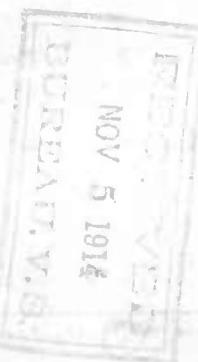
(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dairy laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor", for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

NOV 5 1914



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Montgomery

10137

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 222

Village or City

(No.)

N. Chay Chase

28

St.: Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

Mary Elizabeth Hawkins

PERSONAL AND STATISTICAL PARTICULARS

SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Oct 24, 1875

(Month) (Day) (Year)

7 AGE

38 yrs. 11 mos. 22 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work.
 (b) General nature of industry, business, or establishment in which employed (or employer)

Hawkins

9 BIRTHPLACE

(State or country)

Md

10 NAME OF FATHER

John M. Baker

11 BIRTHPLACE OF FATHER

(State or country)

Md

12 MAIDEN NAME OF MOTHER

Jane Jackson

13 BIRTHPLACE OF MOTHER

(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David Hawkins

(Address) N. Chay Chase

15

Filed Oct 18, 1914 W. L. Lewis

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 16, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, that I attended deceased from

June 15, 1914 to Oct 16, 1914

that I last saw her alive on Oct 16, 1914

and that death occurred on the date stated above, at 6 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lung

34 (Duration) yrs. mos. ds.

Contributory
Secondary

Tuberculosis of lung

34 (Duration) yrs. mos. ds.

(Signed) Aug 17, 1914 (Address) Kensington, M. D.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Oct 18, 1914 (DATE OF BURIAL)

Baltimore, Md.

20 INTERMENT ADDRESS

W. Chapman, Padiddle, Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

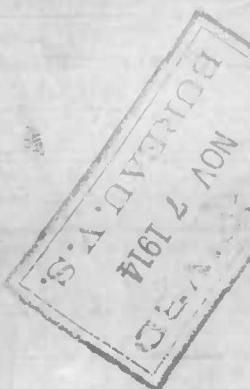
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Thinita," "Collapsus," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uracania," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

10138

County MontgomerySTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218Village or City Garden (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Willard Hawking

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|-------------|-----------------|--|
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
| <u>Male</u> | <u>Colored</u> | <u>Single</u> |

| | | | |
|-----------------|-------------|----------|-------------|
| 6 DATE OF BIRTH | <u>Sept</u> | <u>1</u> | <u>1914</u> |
| | (Month) | (Day) | (Year) |

| | | | | |
|-------|---------------|----------------|--------------|--|
| 7 AGE | <u>yrs. 1</u> | <u>mos. 26</u> | <u>ds. 0</u> | It LESS than 1 day, _____ hrs. OR min. ? |
|-------|---------------|----------------|--------------|--|

| | |
|--------------|--|
| 8 OCCUPATION | (a) Trade, profession, or particular kind of work |
| | <u> </u> |
| | (b) General nature of industry, business, or establishment in which employed (or employer) |

| | |
|------------------------------------|-----------------|
| 9 BIRTHPLACE (State or country) | <u>Maryland</u> |
|------------------------------------|-----------------|

| | |
|--|----------------------|
| 10 NAME OF FATHER | <u>Jack Hawking</u> |
| 11 BIRTHPLACE OF FATHER (State or country) | <u>Maryland</u> |
| 12 MAIDEN NAME OF MOTHER | <u>Susie Stewart</u> |
| 13 BIRTHPLACE OF MOTHER (State or country) | <u>Maryland</u> |

| | |
|--|--|
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | |
|--|--|

| | |
|-------------|---------------------|
| (Informant) | <u>Jack Hawking</u> |
| (Address) | <u>Gathering Rd</u> |

| | | | |
|----------|---------------------|---------------------|--------------|
| 15 Filed | <u>Oct 27, 1914</u> | <u>C. B. Cichon</u> | <u>M. M.</u> |
|----------|---------------------|---------------------|--------------|

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

| | | | |
|------------------|------------|-----------|---------------|
| 16 DATE OF DEATH | <u>Oct</u> | <u>26</u> | <u>, 1914</u> |
| | (Month) | (Day) | (Year) |

| | | |
|---|--------------|------------------|
| 17 I HEREBY CERTIFY, That I attended deceased from | <u>Oct 1</u> | to <u>Oct 26</u> |
| | 1914 | 1914 |
| that I last saw him alive on <u>Oct 25</u> 1914 | | |
| and that death occurred on the date stated above, at <u>9:15</u> m. | | |

The CAUSE OF DEATH was as follows:

| | | | | |
|-------------------|------------|---------------|----------------|--------------|
| <u>Exhaustion</u> | (Duration) | <u>yrs. 1</u> | <u>mos. 26</u> | <u>ds. 0</u> |
|-------------------|------------|---------------|----------------|--------------|

| | | | | | |
|---------------------------|-------------------|------------|---------------|----------------|--------------|
| Contributory Secondary | <u>Exhaustion</u> | (Duration) | <u>yrs. 1</u> | <u>mos. 26</u> | <u>ds. 0</u> |
|---------------------------|-------------------|------------|---------------|----------------|--------------|

| | | |
|------------------------------|-------|----------------------------|
| (Signed) <u>B. N. Cichon</u> | M. D. | (Address) <u>Gathering</u> |
|------------------------------|-------|----------------------------|

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

| | |
|---|--------|
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) | In the |
|---|--------|

| | | | | |
|----------|---------------|----------------|--------------|--------|
| At place | <u>yrs. 1</u> | <u>mos. 26</u> | <u>ds. 0</u> | In the |
|----------|---------------|----------------|--------------|--------|

| | | | | | | |
|----------|---------------|----------------|--------------|---------------------|----------------|--------------|
| of death | <u>yrs. 1</u> | <u>mos. 26</u> | <u>ds. 0</u> | State <u>yrs. 1</u> | <u>mos. 26</u> | <u>ds. 0</u> |
|----------|---------------|----------------|--------------|---------------------|----------------|--------------|

Where was disease contracted,

If not at place of death?

Former or
usual residence.

| | |
|-------------------------------|----------------|
| 19 PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL |
|-------------------------------|----------------|

| | |
|--------------------|---------------------|
| <u>Brook Grove</u> | <u>Oct 28, 1914</u> |
|--------------------|---------------------|

| | |
|---------------|---------|
| 20 UNDERTAKER | ADDRESS |
|---------------|---------|

| | |
|-------------------------|------------------|
| <u>Alex G. Carlisle</u> | <u>Gathering</u> |
|-------------------------|------------------|

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

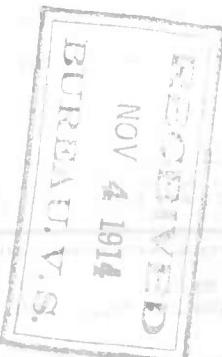
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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDE, or HOMICIDE, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 10139

County Montgomery

79

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 222

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Silver Spring (No.)

2 FULL NAME Richard H Hewitt

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|------------|-----------------------|---|
| 3 SEX Male | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word) |
|------------|-----------------------|---|

| | | | |
|------------------------|---------|------------|--------|
| 6 DATE OF BIRTH Oct. 3 | (Month) | (Day) 1830 | (Year) |
|------------------------|---------|------------|--------|

| | | | |
|--------------|--------|-------|---------------------------------------|
| 7 AGE 84 yrs | — mos. | 9 ds. | If LESS than 1 day, hrs. OR min. ? |
|--------------|--------|-------|---------------------------------------|

| |
|--|
| 8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer) Farmer |
|--|

| |
|---|
| 9 BIRTHPLACE (State or country) England |
|---|

| |
|--------------------------------|
| 10 NAME OF FATHER Aaron Hewitt |
|--------------------------------|

| |
|--|
| 11 BIRTHPLACE OF FATHER (State or country) England |
|--|

| |
|---|
| 12 MAIDEN NAME OF MOTHER Elizabeth Harris |
|---|

| |
|--|
| 13 BIRTHPLACE OF MOTHER (State or country) England |
|--|

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank L Hewitt

(Address) Silver Spring, Md.

15 Filed Oct 13, 1914 H. H. Hewitt, M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 12, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from on October 12, 1914, to _____, 1914,

that I last saw him alive on October 12, 1914,

and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) One yr. — mos. — ds.

Contributory Acute Gastritis
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) Howard H. Hewitt, M.D.

Oct 12, 1914 (Address) Silver Spring, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Forest Glen, Md. DATE OF BURIAL Oct. 15, 1914

20 UNDERTAKER A. G. Carlisle ADDRESS Silver Spring, Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsupium," "Old Age," "Shock," "Traæmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

| | |
|---------------|-------------|
| RECEIVED - | NOV 10 1914 |
| BUREAU, U. S. | |

MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

10140

County Montgomery.Village or City Takoma Park (No.)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistered No. 223

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Sallie Frances Hopkins

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---------------|-----------------|--|
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
| <u>Female</u> | <u>white</u> | <u>Married</u> |

| | | |
|-----------------|---------|--------|
| 6 DATE OF BIRTH | Oct 8 | 1857 |
| | (Month) | (Year) |

| | | |
|-------|----------------------|--|
| 7 AGE | 57 yrs. 6 mos. 1 ds. | It LESS than 1 day, ____ hrs. OR ____ min. ? |
|-------|----------------------|--|

| | |
|--|------------------|
| 8 OCCUPATION | <u>Housewife</u> |
| (a) Trade, profession, or particular kind of work | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | |

| | |
|------------------------------------|-----------------|
| 9 BIRTHPLACE (State or country) | <u>Missouri</u> |
|------------------------------------|-----------------|

| | |
|-------------------|----------------------------|
| 10 NAME OF FATHER | <u>F. C. Y. Brightwell</u> |
|-------------------|----------------------------|

| | |
|--|-------------------------|
| 11 BIRTHPLACE OF FATHER (State or country) | <u>Pembroke Co. Va.</u> |
|--|-------------------------|

| | |
|-----------------------------|-----------------------|
| 12 MAIDEN NAME OF MOTHER | <u>Sallie Hopkins</u> |
|-----------------------------|-----------------------|

| | |
|--|-------------------------|
| 13 BIRTHPLACE OF MOTHER (State or country) | <u>Pembroke Co. Va.</u> |
|--|-------------------------|

| | |
|--|----------------------|
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | <u>J. G. Skinner</u> |
|--|----------------------|

| | |
|-------------|----------------------|
| (Informant) | <u>J. G. Skinner</u> |
|-------------|----------------------|

| | |
|-----------|-------------------------|
| (Address) | <u>Takoma Park, Md.</u> |
|-----------|-------------------------|

| | |
|----|---|
| 15 | Filed <u>Oct 9</u> , 1914 <u>H. E. Rogers</u> |
|----|---|

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 8, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept. 15, 1914, to Oct. 8, 1914, that I last saw him alive on Oct. 7, 1914, and that death occurred on the date stated above, at 8:15 a.m.,

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas and adjacent organs.

(Duration) 2 yrs. — mos. — ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.
(Signed) A. R. Little, M.D.

Oct. 8, 1914. (Address) Takoma Park, D.C.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the _____ State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Glenmont Cemetery Washington, D.C. DATE OF BURIAL Oct 9, 1914

20 UNDERTAKER Joseph Lawler's Sons ADDRESS Wash. D.C.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

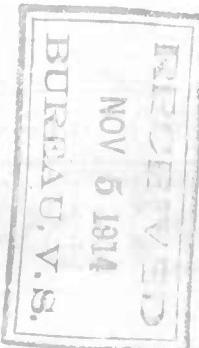
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcinoma*, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc. *Carcin-*



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH
County Montgomery

10141

(79)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St.: _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Mattawang (No.)2 FULL NAME Wm Jackson

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--------------|-----------------|--|
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
| <u>Male.</u> | <u>Colored,</u> | <u>Married</u> |

6 DATE OF BIRTH Unknown
 (Month) (Day) (Year)
 1

| | |
|----------------------|--|
| 7 AGE | If LESS than 1 day,.....hrs. OR min. ? |
| <u>About 72</u> yrs. | mos. ds. |

8 OCCUPATION
 (a) Trade, profession, or
particular kind of work Atom Hand
 (b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE
(State or country) Pa.

10 NAME OF
FATHER Unknown

11 BIRTHPLACE
OF FATHER
(State or country) Unknown

12 MAIDEN NAME
OF MOTHER Unknown

13 BIRTHPLACE
OF MOTHER
(State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rachel Jackson
 (Address) Mattawang Md.

15 Filed Oct 14, 1914 E. White

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 13, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
Sept 1, 1914, to Sept 7, 1914,

that I last saw him alive on Sept 7, 1914,

and that death occurred on the date stated above at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal disease, pneumonia,
wrist and shoulder fracture.

(Duration) Unknown yrs. mos. ds.

Contributory
Secondary

(Duration) EW White yrs. mos. ds.
 (Signed) EW White, M. D.

Oct 14, 1914 (Address) Poolesville

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Mattawang Md. DATE OF BURIAL Oct 15th, 1914

20 UNDERTAKER H. T. Fellont Sons ADDRESS Poolesville

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

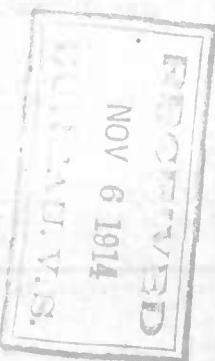
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner, Cotton mill;* (a) *Salesman, (b) Grocery;* (a) *Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coat mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dobility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



NOV 6 1914

N.Y.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 10142
County Montgomery

Village or City Gaithersburg No.

2 FULL NAME Priscilla Jones

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--------------|-------------------------|---|
| 3 SEX Female | 4 COLOR OR RACE Colored | 5 SINGLE, MARRIED, WIDWED, OR DIVORCED (Write the word) Widow |
|--------------|-------------------------|---|

6 DATE OF BIRTH Sept. 1914

(Month) (Day) (Year)

7 AGE 70 yrs. 00 mos. 00 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Servant
(b) General nature of industry, business, or establishment in which employed (or employer) Laundry

9 BIRTHPLACE (State or country) Md.

10 NAME OF FATHER Geo. Brown

11 BIRTHPLACE OF FATHER (State or country) Md.

12 MAIDEN NAME OF MOTHER Dorot. Knowles

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Priscilla Jones

(Address) Gaithersburg Md.

15

Filed Oct 3, 1914 C.P. Elshorn, M.D.

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

10142

64

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 20, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1914, to Oct 2nd, 1914,

that I last saw h. m. alive on Oct 2nd, 1914,

and that death occurred on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Arterial Hemorrhage

(Duration) 12 hrs. yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Oct 3, 1914 (Address) Gaithersburg, M. D.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT

CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Gard. Union Oct 4, 1914

DATE OF BURIAL

20 UNDERTAKER

T.G. Carlisle

ADDRESS

Gaithersburg

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

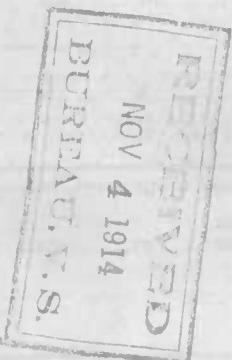
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Maunger," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Cancer-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Amaenia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tranemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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MARGIN RESERVED FOR BINDING

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V. S. No. 1.

1 PLACE OF DEATH

10143

County Montgomery

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 223

Village or City Takoma Park (No. Washington Sanitarium St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Virginia Minor Lammond

PERSONAL AND STATISTICAL PARTICULARS

3 SEX FEMALE, white. 4 COLOR OR RACE MARRIED, WIDOWED, DIVORCED, OR DIVORCEO Widowed (Write the word)

5 DATE OF BIRTH Unknown (Month) (Day) (Year)

6 AGE 65 yrs. mos. ds. If LESS than 1 day, hrs. OR min. ?

7 OCCUPATION (a) Trade, profession, or particular kind of work None (b) General nature of industry, business, or establishment in which employed (or employer)

8 BIRTHPLACE (State or country) Virginia

9 NAME OF FATHER George Dale

10 BIRTHPLACE OF FATHER (State or country) England

11 MAIDEN NAME OF MOTHER Minor

12 BIRTHPLACE OF MOTHER (State or country) Virginia

13 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. H. J. Marsh

(Address) 14 Fairmount Street

14 Filed Oct 28 1914 by L. E. Rogers

REGISTRAR

If more blanks are needed, address State Registrar, 1 E. Franklin St., Balt., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH October 28, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 7, 1914, to Oct 28, 1914,

that I last saw her alive on Oct 28, 1914,

and that death occurred on the date stated above, at 10:05 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

10 (Duration) yrs. mos. ds.
Contributory Cerebral Hemorrhage Secondary

(Duration) yrs. mos. ds.
(Signed) R. S. Divine, M.D.
(Address) Takoma Park Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 21 ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Wash. D.C.

DATE OF BURIAL Oct 30, 1914

20 UNDERTAKER Jos. Gandy's Sons

ADDRESS Wash. D.C.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

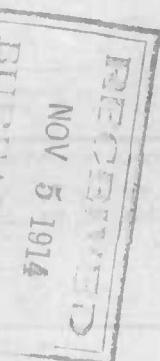
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

oma, *Sarcoma*, etc. of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County *Baltimore* 10144

Village or City *near Dausonville* (No.) 104

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. *2*St. *Ward*)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME *John F. Lee*

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|------------------------|------------------------|--|
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
| <i>Male</i> | <i>Negro</i> | — |
| 6 DATE OF BIRTH | | 7 10, 1914 (Month) (Day) (Year) |
| 7 AGE | | It LESS than 1 day, ... hrs. yrs. 3 mos. — ds. OR min. ? |

8 OCCUPATION
 (a) Trade, profession, or particular kind of work
 —
 (b) General nature of industry, business, or establishment in which employed (or employer)
 —

9 BIRTHPLACE
(State or country) *Maryland*

10 NAME OF FATHER *Lewis. Lee*

11 BIRTHPLACE OF FATHER
(State or country) *Maryland*

12 MAIDEN NAME OF MOTHER *Cassie Scott*

13 BIRTHPLACE OF MOTHER
(State or country) *Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(informant) *Annie Adams*

(Address) *R. F. D# 1 Bellman Rd.*

15 Filed *Oct 10/14* 1914 *E. W. Hale*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH10 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY. That I attended deceased from *Oct 1st*, 1914, to *Oct 10th*, 1914, that I last saw him alive on *Oct 9th*, 1914, and that death occurred on the date stated above, at *2 P.M.* The CAUSE OF DEATH* was as follows:

Intero-colitis

Contributory (Secondary) *Malsnutrition* (Duration) yrs. *10* ds.

(Signed) *J. D. House* M. D. (Duration) yrs. *3* mos. — ds.

(Address) *Dausonville Rd.*

*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Sugar Land Rd. DATE OF BURIAL *Oct 11, 1914*

20 UNDERTAKER *P. H. Davis* ADDRESS *Dausonville Rd.*

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

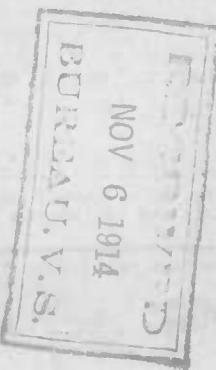
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—*coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *housekeepers* who receive a definite salary), may be entered as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has gainedfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthma," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachoma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train*—accident; *Revolver round of head*—homicide; *Poisoned by carbolic acid*—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 10145

County Maryland

Village or City Poolesville No. 91

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 212

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Viola Virginia Beck

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|---------------------|------------------------------|---|
| 3 SEX <u>Female</u> | 4 COLOR OR RACE <u>Blach</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word) |
|---------------------|------------------------------|---|

6 DATE OF BIRTH

Sept 26, 1914
(Month) (Day) (Year)

| | |
|--------------------------------|--|
| 7 AGE | If LESS than 1 day, ____ hrs. OR ____ min. ? |
| ____ yrs. — mos. <u>23</u> ds. | |

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Sinfant

9 BIRTHPLACE
(State or country)

Md

10 NAME OF FATHER

Thomas Beck

11 BIRTHPLACE OF FATHER
(State or country)

Md

12 MAIDEN NAME OF MOTHER

Minnie Taylor

13 BIRTHPLACE OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Amelia Beck

(Address)

Poolesville

15

Filed

Oct 20, 1914

EW White

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Oct 18, 1914, to Oct 19, 1914,

that I last saw her alive on Oct 18, 1914,

and that death occurred on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(Duration) yrs. — mos. 1 ds.

Contributory
Secondary

(Duration) yrs. — mos. — ds.

(Signed) EW White, M. D.

Oct 20, 1914 (Address) Poolesville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

Aug 20, 1914 Oct 21, 1914

20 UNDERTAKER

Pete Doves ADDRESS Poolesville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

NOV 6 1914

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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V. S. No. 1.

1 PLACE OF DEATH

10146

County

Village or City

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 218

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Aug 18, 1913

(Month) (Day) (Year)

7 AGE

yrs. 1 mos. 17 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF
FATHER11 BIRTHPLACE
OF FATHER

(State or country)

12 MAIDEN NAME
OF MOTHER13 BIRTHPLACE
OF MOTHER

(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed Oct 6, 1914 C. R. Etchison M. D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

Oct 5, 1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 21, 1914, to Oct. 5, 1914, that I last saw him alive on Oct 4, 1914,

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Enterovirus

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Oct 6, 1914 (Address) Gaithersburg, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence

20 PLACE OF BURIAL OR REMOVAL

Gaithersburg

20 UNDERTAKER

A. G. Parklith

DATE OF BURIAL

Oct 7, 1914

ADDRESS

Gaithersburg

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 d.s.*; *Bronchopneumonia* (secondary), *10 d.s.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Coughing"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as—"UTERINE septicemia," "PUERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinosis*

NOV 4 1914

BURLEAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Maryland

10147

36

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

Village or City Commodore

(No.)

St. _____ Ward _____

2 FULL NAME

Wm Mansfield

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED
*(Write the word)*Single

6 DATE OF BIRTH

Oct - 1842

(Month) (Day) (Year)

7 AGE

72

yrs. — mos. — ds.

If LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)MillerFloor Mill

9 BIRTHPLACE

(State or country)

Md -

10 NAME OF FATHER

Chas Mansfield11 BIRTHPLACE OF FATHER
(State or country)Md -

12 MAIDEN NAME OF MOTHER

Whalen13 BIRTHPLACE OF MOTHER
(State or country)Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Chas Mansfield

(Address)

Gaithersburg Md

15

Aug 21, 1914J. G. Deeks

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 28, 1914

(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

This man was found dead, 1914,

that I last saw him alive on, 1914,

and that death occurred on the date stated above, at, 1914,

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

Contributory Alcoholism

Secondary

(Duration) yrs. mos. ds.

(Signed) J. K. Eichingers, M. D.10/31, 1914 (Address) Commodore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Commodore Md Oct 1, 1914

20 UNDERTAKER

A. G. Carlisle Jack J. Dunn

DATE OF BURIAL

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Gastric-*

oma, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

19149

County MontgomerySTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 218Village or City Gaithersburg (No.)

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George W. Meun

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--------------|------------------------|--|
| <u>3 SEX</u> | <u>4 COLOR OR RACE</u> | <u>5 SINGLE, MARRIED, WIDOWED, OR DIVORCED</u> (Write the word) |
| <u>Male</u> | <u>white</u> | <u>married</u> |

6 DATE OF BIRTHSept 3, 1842
(Month) (Day) (Year)7 AGE72 yrs 1 mos 10 ds.It LESS than
1 day, hrs.
OR min. ?8 OCCUPATION

(a) Trade, profession, or particular kind of work.
Carpenter & builder of houses, (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Washington D.C.

PARENTS

10 NAME OF FATHERGeo. A. Meun11 BIRTHPLACE OF FATHER

(State or country)

Georgetown12 MAIDEN NAME OF MOTHERMartha A. Jones13 BIRTHPLACE OF MOTHER

(State or country)

Georgetown14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE(Informant) Marion L. G. Meun(Address) Gaithersburg15Filed Oct 15, 1914 C. P. Hutchinson, M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct - 13"
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct - 1914, to Oct 13", 1914,
that I last saw him alive on Oct 13", 1914,
and that death occurred on the date stated above, at 9:30 a.m.
The CAUSE OF DEATH* was as follows:

Paralysis Agitans
(Parkinson)(Duration) 10 yrs. — mos. — ds.Contributory
Secondary(Duration) — yrs. — mos. — ds.

(Signed) W. B. Haddad M. D.
Oct 13, 1914 (Address) Gaithersburg

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)At place 25 yrs. — mos. — ds. In the State 25 yrs. — mos. — ds.Where was disease contracted, if not at place of death? DentFormer or usual residence Washington D.C.19 PLACE OF BURIAL OR REMOVAL DATE OF BURIALSt Rose Oct 15, 191420 UNDERTAKER ADDRESSW. R. Murphy & Son Rickville

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meningitis*, *peritonitis*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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| | |
|---------------|------------|
| RECEIVED | NOV 4 1914 |
| BUREAU, V. S. | |

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

| | | |
|--|-----------------|--|
| 1 PLACE OF DEATH | | 10148 |
| County | | Montgomery |
| Village or City | | near Mt. Ephraim (No.) |
| 154 | | |
| 2 FULL NAME Cassandra Moody | | |
| PERSONAL AND STATISTICAL PARTICULARS | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
| Female | Colored | Single |
| 6 DATE OF BIRTH | | |
| | Mar | , 1825 |
| | (Month) | (Day) |
| | | (Year) |
| 7 AGE | 89 yrs | 7 mos. — ds. |
| | | IT LESS THAN 1 day, ____ hrs. OR min. ? |
| 8 OCCUPATION | | |
| (a) Trade, profession, or particular kind of work. | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| At home | | |
| 9 BIRTHPLACE (State or country) | | |
| Maryland | | |
| 10 NAME OF FATHER | | |
| Dout know | | |
| 11 BIRTHPLACE OF FATHER (State or country) | | |
| Maryland | | |
| 12 MAIDEN NAME OF MOTHER | | |
| Doreas A Moody | | |
| 13 BIRTHPLACE OF MOTHER (State or country) | | |
| Maryland | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | |
| William Proctor (Informant) | | |
| Dickenson Md (Address) | | |
| 15 Filed Oct 8, 1914 J. M. White | | |

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 220

St. _____ Ward _____

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 7, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Had no physician
1914 to 1914,that I last saw h alive on 1914
Never saw her 1914

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Had no physician
supposed to be old age

(Duration) yrs. mos. ds.

Contributory
Secondary(Signed) J. M. White, M.D.
Oct 8, 1914 (Address) Banneville Md*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-
DENTAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)At place _____ yrs. _____ mos. _____ ds. In the _____
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ dsWhere was disease contracted,
If not at place of death?Former or
usual residence _____19 PLACE OF BURIAL OR REMOVAL
Mt. Ephraim Md Oct 9, 1914
DATE OF BURIAL20 UNDERTAKER
Wm. P. Hilton Sons Banneville
ADDRESS

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

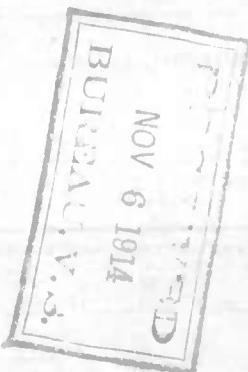
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonitum, etc.*; *Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Dehility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: "Accidental drowning"; "Struck by railway train—accident"; "Revolver wound of head—homicide"; "Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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| | | |
|---|------------------------------|---|
| 1 PLACE OF DEATH County <u>Montgomery</u> | | 10150 |
| (No.) | | |
| 29 | | |
| Village or City <u>Silver Spring</u> | | St.: Ward) |
| 2 FULL NAME <u>Walter Newman</u> | | |
| PERSONAL AND STATISTICAL PARTICULARS | | |
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Divorced</u> (Write the word) |
| 6 DATE OF BIRTH <u>December 22, 1857</u> (Month) (Day) (Year) | | |
| 7 AGE <u>56 yrs. 9 mos. 27 ds.</u> If LESS than 1 day, hrs. OR min. ? | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work <u>P. R. R. Conductor</u> (b) General nature of industry, business, or establishment in which employed (or employer) | | |
| 9 BIRTHPLACE (State or country) <u>Prince George Co. Maryland</u> | | |
| 10 NAME OF FATHER <u>Francis L. Newman</u> | | |
| 11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u> | | |
| 12 MAIDEN NAME OF MOTHER <u>Rachel M. Anderson</u> | | |
| 13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u> | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. W. H. Bradbury</u> (Address) <u>Washington Grove, Md.</u> | | |
| 15 Filed <u>Oct. 19, 1914 C. N. Titcham, M.D.</u> | | |

| | | |
|--|---|--|
| STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. 218 | | |
| [If death occurred in a hospital or institution, give its NAME instead of street and number.] | | |
| MEDICAL CERTIFICATE OF DEATH | | |
| 16 DATE OF DEATH <u>10 19, 1914</u> (Month) (Day) (Year) | I HEREBY CERTIFY That I attended deceased from <u>Oct. 15, 1914</u> , to <u>Oct. 19, 1914</u> | |
| that I last saw him alive on <u>Oct. 15, 1914</u> | | |
| and that death occurred on the date stated above, at <u>12:30 A.m.</u> | | |
| The CAUSE OF DEATH* was as follows: | | |
| <u>Pulmonary Tuberculosis</u> | | |
| (Duration) <u>2 yrs. mos. ds.</u> | | |
| Contributory Secondary | | |
| (Duration) <u>John L. Lewis, M. D.</u> (Signed) <u>John L. Lewis, M. D.</u> (Address) <u>Bethesda, Md.</u> | | |
| * State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL. | | |
| 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ yrs. _____ mos. <u>4</u> ds. In the State _____ yrs. _____ mos. <u>4</u> ds. Where was disease contracted, if not at place of death? <u>Washington D.C.</u> | | |
| Former or usual residence <u>Washington D.C.</u> | | |
| 19 PLACE OF BURIAL OR REMOVAL <u>Washington D.C.</u> DATE OF BURIAL <u>Oct. 21, 1914</u> | | |
| 20 UNDERTAKER <u>Jeff P. Murphy</u> ADDRESS <u>Brookville</u> | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cotton*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Turner* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or unscarriage as "*Puerperal septicæmia*," "*Puerperal poritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scpsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

NOV 4 1914

BUREAU, V.S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

10151

County

Montgomery

Village or City

Rockville

(No.)

104

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 213

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Alice Poole

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

white

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

single

6 DATE OF BIRTH

Nov 20th, 1913
(Month) (Day) (Year)

7 AGE

yrs. 10 mos. 17 ds.
If LESS than
1 day, _____.hrs.
OR _____.min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

none

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF
FATHER

Clinton Poole

11 BIRTHPLACE
OF FATHER
(State or country)

Md

12 MAIDEN NAME
OF MOTHER

Laura Fitzel

13 BIRTHPLACE
OF MOTHER
(State or country)

Ia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

Alice Poole

Rockville Md

15

Filed _____, 191_____

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 7, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Aug 30th, 1914, to Oct 7, 1914,

that I last saw her alive on Oct 7, 1914,

and that death occurred on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH* was as follows:

Enteritis - colitis

(Duration) yrs. 1 mos. 9 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) H. A. Henderson, M. D.
Oct 7, 1914 (Address) Rockville Md*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)At place _____ yrs. _____ mos. _____ ds. In the
of death _____ yrs. _____ mos. _____ ds. State _____ yrs. _____ mos. _____ dsWhere was disease contracted,
if not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

Rockville Md

DATE OF BURIAL

Oct 9, 1914

20 UNDERTAKER

Mr. Murphy, Son

ADDRESS

Rockville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meningitis, peritonacum, etc.*, *Carcin-*oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Amenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Contingent," "Sequel," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
NOV 7 1914

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PARENTS

10 NAME OF FATHER

Richard Walker
Virginia

11 BIRTHPLACE OF FATHER
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Anne Oliver
Virginia

13 BIRTHPLACE OF MOTHER
(State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Benj. T. Walker
Crosby, Md.

(Address)

15

Filed Oct 16, 1914
Myrtle

REGISTRAR

PLACE OF DEATH

County Maryland

10152

169

Village or City Great Lakes

No. Cora B. Walker Bush

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 219

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female.

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Walker, 1878
(Month) (Day) (Year)

7 AGE

36 yrs. X mos. X ds. If LESS than
1 day.....hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

housework

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

Richard Walker
Virginia11 BIRTHPLACE OF FATHER
(State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Anne Oliver

13 BIRTHPLACE OF MOTHER
(State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Benj. T. Walker
Crosby, Md.

(Address)

15

Filed Oct 16, 1914
Myrtle

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 5th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1914, to Oct 16, 1914, dead that I last saw him alive on Oct 16, 1914, and that death occurred on the date stated above, at 11:30 P. m. The CAUSE OF DEATH* was as follows:

Accidental drowning

(Duration) yrs. mos. ds.

Contributory
Secondary

M. D. (Duration) yrs. mos. ds.

(Signed) M. D. (Address) Oct 16, 1914, Pollock's Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL
Oct 7th, 1914

20 UNDERTAKER

ADDRESS
Richards, Md.

REVISED UNITED STATES STANDARD

[Approved by U. S. Census and American Public Health Association.]

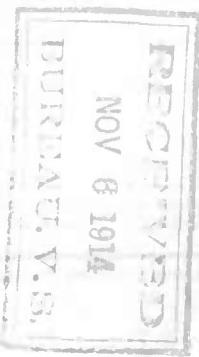
CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

oma, *Sarcoma*, etc. of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital"), "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicemia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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DURRANT, V. B.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 10153
County Montgomery

Village or City Potowmack (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 219

St. Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME William Shedd

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married

6 DATE OF BIRTH UNKNOWN, 1842
(Month) (Day) (Year)

7 AGE About 72 yrs. 7 mos. 7 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Day laborer (farm)
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE North Carolina
(State or country)

10 NAME OF FATHER UNKNOWN

11 BIRTHPLACE OF FATHER (State or country) UNKNOWN

12 MAIDEN NAME OF MOTHER UNKNOWN

13 BIRTHPLACE OF MOTHER (State or country) UNKNOWN

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ruth Shedd
(Address) Potowmack Md.

15 Filed Oct 1st, 1914 Mrs. M. Shedd
by [Signature]

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 1st, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1914, to Oct 1st, 1914, that I last saw him dead Oct 1st, 1914, and that death occurred on the date stated above, at 6:25 A.M. The CAUSE OF DEATH* was as follows:

Diseases heart lesions.
(Duration) UNKNOWN yrs. mos. ds.

Contributory Secondary
(Duration) UNKNOWN yrs. mos. ds.

(Signed) H. P. Hall (Address) Potowmack Md., M. D.
Oct 1st, 1914

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. To the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted.
If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Potowmack Md. Union Wesley Ch. DATE OF BURIAL Oct 3rd, 1914

20 UNDERTAKER M. J. Shedd ADDRESS Rockville Md.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

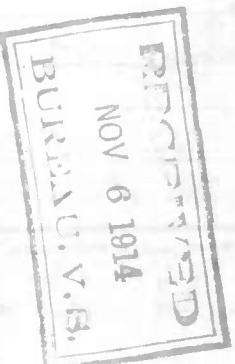
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Panter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

oma, Sarcoma, etc. of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital"), "Senile," etc., "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—dent*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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| | | | |
|--|-----------------|--|------|
| 1 PLACE OF DEATH | | 10154 | (89) |
| County | | Montgomery | |
| Village or City | | near Blaggettsville | |
| 2 FULL NAME | | | |
| Rosie Thomas | | | |
| PERSONAL AND STATISTICAL PARTICULARS | | | |
| 3 SEX | 4 COLOR OR RACE | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) | |
| Female colored | Single | | |
| 6 DATE OF BIRTH | | | |
| Sept. 4 th , 1914 | | | |
| (Month) (Day) (Year) | | | |
| 7 AGE | | | |
| — yrs. — mos. — ds. | | | |
| If LESS than 1 day, hrs. OR min. ? | | | |
| 8 OCCUPATION | | | |
| (a) Trade, profession, or particular kind of work | | | |
| (b) General nature of industry, business, or establishment in which employed (or employer) | | | |
| Baby | | | |
| 9 BIRTHPLACE (State or country) | | | |
| Montgomery Co., Md. | | | |
| 10 NAME OF FATHER | | | |
| Joseph Wilson Thomas | | | |
| 11 BIRTHPLACE OF FATHER (State or country) | | | |
| Montgomery Co., Md. | | | |
| 12 MAIDEN NAME OF MOTHER | | | |
| Sarah E. Dorsey | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) | | | |
| Montgomery Co., Md. | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE | | | |
| J. W. Thomas (Informant) | | | |
| (Address) | | | |
| Mt. Airy, Md. | | | |
| 15 | | | |
| Filed....., 191..... | | | |

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 221

St. Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

1B DATE OF DEATH
Oct. 4th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
Oct. 3rd, 1914, to Oct. 4th, 1914,
that I last saw her alive on Sat. Oct. 3rd, 1914,
and that death occurred on the date stated above, at 4 P. m.,

The CAUSE OF DEATH* was as follows:

Capillary Bronchitis

(Duration) — yrs. — mos. 5 ds.

Contributory
(Secondary)

(Duration) — yrs. — mos. ds.

Signed) J. Albert Rice, M. D.
Oct. 5th, 1914 (Address) Mt. Airy, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-
DENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

In place
at death yrs. mos. ds. In the
Where was disease contracted,
If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL
Friendship Cem., Oct 6, 1914

20 UNDERTAKER
Blk. Bowman McAnigle

DATE OF BURIAL

ADDRESS

REGISTRAR

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traenium," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Tubercular scrophulae*," "*Tubercular peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SURGICAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scaphis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 10155

County Montgomery

(151)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 210

Village or City Laytonville (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Helen Walker

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|--------------|-----------------------|---|
| 3 SEX Female | 4 COLOR OR RACE white | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) |
|--------------|-----------------------|---|

6 DATE OF BIRTH

Oct 12, 1914
(Month) (Day) (Year)

| | |
|-------|--|
| 7 AGE | If LESS than 1 day, <u>2</u> hrs. 0 yrs. 0 mos. 0 ds. OR min. ? |
|-------|--|

| | |
|--|---------|
| 8 OCCUPATION (a) Trade, profession, or particular kind of work | in ganz |
| (b) General nature of industry, business, or establishment in which employed (or employer) | |

| | |
|------------------------------------|------------------|
| 9 BIRTHPLACE (State or country) | Montgomery Co Md |
|------------------------------------|------------------|

| | |
|-------------------|----------------------|
| 10 NAME OF FATHER | Nathan Walker Walker |
|-------------------|----------------------|

| | |
|---|------------------|
| 11 BIRTHPLACE OF FATHER (State or country) | Montgomery Co Md |
|---|------------------|

| | |
|--------------------------|----------------|
| 12 MAIDEN NAME OF MOTHER | Virginia B Ray |
|--------------------------|----------------|

| | |
|---|------------------|
| 13 BIRTHPLACE OF MOTHER (State or country) | Montgomery Co Md |
|---|------------------|

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Virginia B Walker

(Address) Deswood 3rd RFD #1

Filed Oct 12, 1914 V. T. Dyer

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

18 DATE OF DEATH

Oct 12, 1914
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from

Oct 12, 1914, to Oct 12, 1914

that I last saw her alive on Oct 12, 1914

and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Formation Birth
not down there & down
in Ultra, lived 2 hours
(Duration) ✓ yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) V. T. Dyer, M. D.
Oct 12, 1914 (Address) Laytonville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

16 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or usual residence

17 PLACE OF BURIAL OR REMOVAL
Laytonville, Walker County, Oct 12, 1914DATE OF BURIAL
ADDRESS
J F Bunniss

20 UNDERTAKER

ADDRESS
Laytonville Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

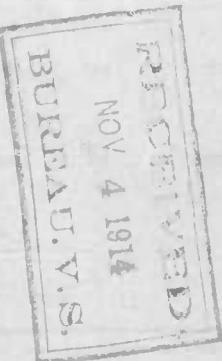
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a), *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Mauager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back or certificate.

1 PLACE OF DEATH

County Montgomery 19156
Village or City Germantown (No.)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 21

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Sarah Lavinia Warfield

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Lady

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Single

6 DATE OF BIRTH

Oct 3, 1852

(Month)

(Day)

(Year)

7 AGE

62 yrs. - mos. 6 ds.If LESS than
1 day, ____ hrs.
OR ____ min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work.(b) General nature of industry,
business, or establishment in
which employed (or employer)At home9 BIRTHPLACE
(State or country)Montgomery Ind10 NAME OF
FATHEREdwin Warfield11 BIRTHPLACE
OF FATHER
(State or country)Montgomery Ind12 MAIDEN NAME
OF MOTHERSarah A. Darby13 BIRTHPLACE
OF MOTHER
(State or country)Montgomery Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Grace L. Warfield

(Address)

Germantown Ind

15

Filed _____, 191

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

10 7, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from
Patient was dead when
call to see her
that I last saw h _____ alive on _____, 1914.

and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was a stroke 3-1914.

(Duration) yrs. mos. ds.

Contributory (Secondary) Scattered indigestion

red hives Angina Pectoris (Duration) Badly mos. ds.

(Signed) J. N. Simper, M.D.

10/31, 1914 (Address) Germantown Ind

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Germantown Ind DATE OF BURIAL 10/10, 1914

20 UNDERTAKER

R.W. Pennington Rockville Md ADDRESS

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health

Association.]

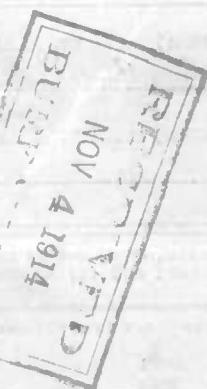
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salorman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cercbrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc. *Carcin-*

oma

oma. Sarcoma, etc., of _____ (name origin; "Can-
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic vascular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County.....
Village or City.....

10157

151

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 221

St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Howard Murray Wathens

| PERSONAL AND STATISTICAL PARTICULARS | | | | MEDICAL CERTIFICATE OF DEATH | | | |
|---|--------------------------|--|--|---|--|--|--|
| 3 SEX Male | 4 COLOR OR RACE White | 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single | | 16 DATE OF DEATH Oct. 3d., 1914 (Month) (Day) (Year) | | | |
| 6 DATE OF BIRTH Sept. 4, 1914 (Month) (Day) (Year) | | | | 17 I HEREBY CERTIFY, That I attended deceased from —, 1914, to —, 1914 that I last saw him alive on Sept. 6, 1914 and that death occurred on the date stated above, at 1 p.m. The CAUSE OF DEATH* was as follows: <i>Premature Birth (6 1/2 month)</i> | | | |
| 7 AGE — yrs. — months — days. | | | | II LESS than 1 day, — hrs. OR — min. ? | | | |
| 8 OCCUPATION (a) Trade, profession, or particular kind of work — (b) General nature of industry, business, or establishment in which employed (or employer) — | | | | (Duration) yrs. mos. ds. | | | |
| 9 BIRTHPLACE (State or country) Md. | | | | | | | |
| 10 NAME OF FATHER Harry Wathens | | | | Contributory (Secondary) | | | |
| 11 BIRTHPLACE OF FATHER (State or country) Md. | | | | (Duration) yrs. mos. ds. (Signed) <i>See. M. Boyer</i> , M. D. Oct. 3, 1914 (Address) <i>Danvers, Md.</i> | | | |
| 12 MAIDEN NAME OF MOTHER Estelle Pickett | | | | * State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. | | | |
| 13 BIRTHPLACE OF MOTHER (State or country) Md. | | | | 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence | | | |
| 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Harry Wathens (Address) Mt. Airy, Md. | | | | 19 PLACE OF BURIAL OR REMOVAL Howard Chapel Cemetery 20 UNDERTAKER B. N. Bowman Mt. Airy, Md. | | | |
| 15 Filed....., 1914. | | | | DATE OF BURIAL Oct. 4, 1914 | | | |
| | | | | ADDRESS | | | |

**REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH**

[Approved by U. S. Census and American Public Health

ASSOCIATION.

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—("on mine," etc.). Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is Indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc. *Carcin-*

oma. *Sarcoma, etc., of* _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles;* *Whooping cough;* *Chronic valvular heart disease;* *Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), **29 as:** *Bronchopneumonia* (secondary), **10 ds.** Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con- *genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "*Puerperal septicemia,*" "*Puerperal peritonitis,*" etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning;* *Struck by railway train—accident;* *Recoiled round of head—homicide;* *Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

10158

County Montgomery

113

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 2 1 b

Village or City Bethesda Chase (No.) Broad Branch Rd. St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Henry L. Wolford

PERSONAL AND STATISTICAL PARTICULARS

| | | |
|-------------------|------------------------------|---|
| 3 SEX <u>Male</u> | 4 COLOR OR RACE <u>White</u> | 5 SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u> (Write the word) |
|-------------------|------------------------------|---|

6 DATE OF BIRTH

4 18, 1871
(Month) (Day) (Year)

7 AGE

43 yrs. 4 mos. 18 ds. If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)D.C.

10 NAME OF FATHER

Henry L. Wolford11 BIRTHPLACE OF FATHER
(State or country)D.C.

12 MAIDEN NAME OF MOTHER

Sarah E. Weil13 BIRTHPLACE OF MOTHER
(State or country)D.C.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

Informant Henry L. Wolford
(Address) Bethesda Chase, Md.

15

Filed Sept 8, 1914 Franklin M.D.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct - 4, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept 14, 1914 to Oct 16, 1914
that I last saw him alive on Sept 14, 1914

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Insufficiency of liver + interstitial nephritis

(Duration) yrs. mos. ds.

Contributory Secondary Congestion of lungs

(Duration) yrs. mos. ds.

(Signed) Thos K. Conrad, M.D.,
Sept 8, 1914 (Address) Bethesda Chase, Md.

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Wash D.C. DATE OF BURIAL
Oct 8, 1914

20 UNDERTAKER

G.W. Wise ADDRESS
2900 M St.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or incurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as, *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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